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## ‘Asneezia’—A Hitherto Unrecognised Psychiatric Symptom

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It has been the experience of the author that some patients present with absence of sneezing as a prominent part of their symptomatology, and that both the patient and his relatives are disturbed over the symptom. However, no standard psychiatric textbook mentions this symptom, which for lack of a better name, will be referred to here as ‘asneezia’—signifying absence of sneezing or inability to sneeze.

### Method

During a period of three years (1981–1983), a total of 4990 new cases attended the psychiatric services of MLB Medical College, Jhansi. Of these, 53 spontaneously complained of asneezia, and formed the sample for the present study. The remaining 4937 cases served as controls. Detailed history taking and psychiatric examination were carried out in all cases. The patients were given appropriate treatment for their psychiatric condition, and were followed-up to assess the effect of change in the psychiatric condition (improvement or otherwise) on asneezia.

The records were analysed to determine any relationship between the symptom of asneezia and socio-demographic or clinical variables in the two groups.

### Results

The 53 who complained of asneezia gave a frequency of 1.1%. The average age of these patients ( $38.9 \pm 13.5$  years) was higher than that of the controls ( $27.8 \pm 11.6$  years), the difference being statistically significant ( $t = 6.0$ ;  $P < 0.001$ ). This was mainly because there was no case below the age of

20 in the asneezia group, while more than a quarter of the cases in the control group were in this age-group. In both the groups, the highest number of cases were in the third decade (40% in both). The asneezia group had a second peak in the sixth decade.

Females were slightly over-represented in the asneezia group over males, whereas controls had a reverse proportion, but the difference was not significant ( $\chi^2 = 1.05$ ;  $P < 0.25$ ).

Asneezia occurred more commonly in the poorly educated, more than half being illiterate and nearly a quarter educated to primary school level. None had received college education. The controls were better educated, and the difference was highly significant ( $\chi^2 = 16.6$ ;  $P < 0.001$ ).

Socio-economically, the asneezia group was inferior to the controls ( $\chi^2 = 4.5$ ;  $P < 0.05$ ). None of the cases in the former group came from the upper class, less than one-quarter were from the middle-class, while more than three-quarters were of the lower socio-economic status.

The main diagnostic groups in the asneezia group were endogenous depression and schizophrenia, the remaining cases being equally divided between neurotic depression and hypochondriasis. The difference between the controls and the asneezics ( $\chi^2 = 37.4$ ;  $P < 0.001$ ) was mainly on account of endogenous depression, with 16.0 and 43.4% of the cases respectively in the two groups having the condition. Further, more than one-third of the controls was formed by other diagnostic entities which did not figure at all in the asneezia group. (Full data are available on application to the author.)

The response to treatment was universally good in both schizophrenia and endogenous depression, where asneezia disappeared with improvement in the psychiatric condi-

tion with pharmacotherapy and/or E.C.T. However, three out of five hypochondriacs and two out of five neurotic depressives continued to have asneezia as well as psychiatric symptoms, despite treatment. In the remaining two and three cases respectively, asneezia disappeared, even though the psychiatric symptoms persisted to some extent.

TABLE  
Diagnostic analysis

Diagnosis	Asneezics		Controls	
	No.	%	No.	%
Schizophrenia	20	37.8	1640	33.2
Endogenous depression	23*	43.4	789	16.0
Neurotic depression	5	9.4	602	12.2
Hypochondriasis	5	9.4	103	2.1
Others	—	—	1803	36.5
Total	53	100.0	4937	100.0

$$\chi^2 = 37.4; \text{d.f.} = 3; P < 0.001$$

\*Twenty cases had involuntal depression and 3 had first attack of endogenous depression at a younger age.

### Discussion

*Naswar, Sunghani* or snuff—a form of refined tobacco—has been in use in India for centuries, to stimulate the nostrils and thereby producing a series of explosive sneezes. Seen in this light, it is not surprising that people get worried if they are unable to sneeze. The problem is how to relate asneezia with the patient's total symptomatology, and to elucidate its pathophysiological basis. Further, the symptom appears peculiar to patients from India and perhaps other developing countries, since none of the Western textbooks mentions it in their descriptions of psychiatric disorders. This conjecture gets further support from the observation that asneezics tended to come from a lower socio-

economic background and to be poorly educated. Nevertheless, even the vast literature on Indian medicine has not recognised asneezia as a symptom.

In Indian medicine, the value of sneezing has been long recognised. One of the important methods of treatment, aiming at the restoration of the balance of humours, was carried out by applying herbal decoctions to the nose, which loosened the dried phlegm and expelled it from the head through the nasal passage—the so-called nasal drainage (Mora, 1980). African traditional healers believed that mental patients had worms in their heads; these worms were supposed to have hairy bodies which interfered with brain function, excitement and depression/withdrawal occurring due to the worms being awake and asleep respectively. As a consequence, the treatment consisted of removing the worms by giving the patient medicines to make him sneeze violently (Giel *et al.*, 1968; Leff, 1981).

Schizophrenics have been found less likely to suffer from psychosomatic disease than the average person, and they also seem to suffer less frequently from various allergies (Lehmann, 1980) and to be resistant to relatively high doses of histamine (Verghese, 1984). Acute schizophrenics often manifest the autonomic triad of dilated pupils, moist palms, and moderate tachycardia—indicating sympathetic excitation. This may be present even when the patient shows no outward signs of increased emotional tension, and is thus a manifestation of the prevailing functional dissociation. Depressives, on the other hand, have been demonstrated to have raised levels of plasma corticosteroids (Slater & Roth, 1977). All these—sympathetic overactivity, reduced histamine response, and raised levels of corticosteroids—can reduce sneezing. However, they do not completely explain the symptom, which certainly deserves more intensive study, since it might throw light on the mechanism of causation of a whole gamut of important psychiatric diseases.

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